ORIGINAL ARTICLES

EXPLORING THE CAUSES OF LOW REPORTING OF MEDICO-LEGAL ISSUES IN GHANA: PERSPECTIVES OF KEY INFORMANTS IN THE HEALTH SECTOR

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Abstract

Objective: The study aimed at exploring factors leading to medico-legal issues and why they are under reported.
Methodology: This was a qualitative study in which 16 key informants were interviewed with a semi-structured questionnaire. Ethical approval was obtained from the Ghana Institute of Management and Public Administration (GIMPA) Ethical Review Board. Data was analysed thematically. A written informed consent was obtained from each participant.
Results: A medico-legal issue arose if the standard of care was perceived to have been breached or when a complaint was not managed according to the complainant's expectations. Reasons for low reporting included the long emotionally exacting and expensive adjudication process. Additionally, procedures at the facilities to address complaints are considered non-transparent and prejudicial. Finally, interviewees were credulous believing in predetermined death. They have the attitude of 'leave judgement to God.' Even if the victim wants to take the matter up, others may impress upon them to stop it.
Conclusion: The study concludes that factors leading to medico-legal issues include a breach in the approved standard of care of the patient and whether the complainant is unhappy with the handling of the matter. The emotionally and financially exacting nature of dealing with these issues, and the perceived unfair processes account for the low reporting. Belief in fatalism is a contributory factor.

Key words: *Medico-legal, reporting, contributory factors*

Introduction

The ethics of the medical profession hinge on the fundamental values of autonomy, confidentiality, justice, beneficence, and non-maleficence[1]. Medical professionals have a legal duty to comply with these ethical principles in their day-to-day practice. This is because ignorance of, or deviation from these and the possible fall outs thereof, may lead to an occurrence of a medico-legal issue. Another reason is that even when the professional has acted in good faith, the action may not stand the scrutiny of the legal system when subjected to strict analysis. With the increasing number of medico-legal issues worldwide, it is imperative that medical professionals are conversant with fundamental legal issues in medical practice through continuing medico-legal education.

The most frequent forms of medico-legal issues faced by medical professionals are medical negligence, professional misconduct, false imprisonment, assault and battery, euthanasia, and vicarious liability[2]. Others are misdiagnoses or failure to diagnose, failure to obtain an informed consent[3] failure to warn the patient of the known risks involved in treatment and improper treatment.[4]

It is the case that legal implications may arise from the mere alteration in the fundamental practice of medicine and the health practitioner must be aware of this. Practitioners must be mindful of the risks that their medical practice is faced with daily, both from the legal perspective and from the patient's perspective. It is common knowledge that a well-publicized malpractice suit can do irreparable damage to the reputation and practice of a practitioner and their organisation. However, many Ghanaian practitioners are not concerned because few really get reported or sued. Others know that scandals involving them or the facilities may only appear in the media and nothing more so they seem unperturbed.

Anecdotally, it is known that even with the best of intentions and effort, adverse events may occur. However, how they are dealt with may predict how far the issue goes. Often, an honest explanation and a sincere apology may be all it takes to prevent a lawsuit. Unfortunately, most clinicians think that this would imply the admission of guilt and make them vulnerable to a claim. However, all clinicians are encouraged to apologise to the patient where necessary.[5]

Worldwide, medico-legal suits against private and public healthcare providers have soared especially with regards to suits relating to maternal and child health. This is reported to have the potential to severely affect reproductive health services in South Africa.[6] With

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public sector providers, the breach of medical guidelines and practices have been attributed to low-resources and lack of proper management systems.[6] On the other hand, the private sector has been criticised for its non-existent accountability systems coupled with increased patient assertiveness resulting from enhanced knowledge of their rights.[6] Legislative and dispute resolution framework have seen them also faced with increasing medico-legal suits.[6]

In Ghana, there is the perception among healthcare workers that patients can be treated anyhow as though there are neither laws nor professional ethics guiding their conduct.[7] These healthcare workers behave like, "we are doing you a favour therefore, you cannot complain".[7] Unfortunately, most of the populace are not aware of the laws which ensure their rights and privileges. Hence, they hesitate to register their disapproval when these rights are disregarded - advertently or otherwise.[7] The country's difficult economic situation further complicates the issue. Poor people are usually uneducated or under-educated, unempowered and vulnerable, and they overly spiritualise every situation and have 'a-give-it-to-God' attitude. They are ignorant of their entitlements and are unable to launch a complaint at the court and see to its logical conclusion due to lack of funds, and because they feel like they do not have a choice. However, the recognition of healthcare as a human right empowers the holders of these rights to demand accountability from the obligation bearers.[8]

The main objective of this study was to explore the reasons for low reporting of medico-legal issues in Ghana in spite of the fact that such issues do exist in Ghana.

Materials and Methods

The study was a retrospective, purposive study. It was a qualitative study involving the interview of officials who were knowledgeable, communicative, impartial and willing to shed light on the subject matter. They held key positions in the various health institutions and had information germane to the topic of interest. These people were selected because of the positions they held and the pertinent roles they played in Ghana's health sector. Their views, perceptions and experiences on the common causes of medico-legal problems, as well as the factors that determine whether a patient formally reports an incident or not were explored. Also, patients who had suffered an unfortunate incident and the relations of patients who sadly passed away during or following medical treatment were interviewed.

A semi-structured interview guide developed by the primary author was used. The interview instrument was used to organise and guide the interviews. The guide included interviewee-specific, follow-up questions within and across the interviews. Probing and follow-up questions were used as and when necessary, during the interview. Different categories of interviewees were administered with specific questions.

Study Sites and Population

The Ministry of Health (MOH), the Ghana Health Service (GHS), the Medical and Dental Council (MDC), the Korle-Bu Teaching Hospital (KBTH), the Greater Accra Regional Hospital (GARH), the Attorney-General's Department (AGD), a law firm, and the homes and workplaces of patients and their relations were used. The study population comprised officials of the regulatory bodies, notably the MDC, GHS, MOH, KBTH, GARH, and the AGD. These officials receive and deal with such matters of medico-legal issues. Also, a lawyer from a private law firm as well as patients and relations of patients who had suffered an adverse outcome and may have resorted to one form of redress or the other, were among the interviewees. The study aimed to sample a total of 17 persons, but one person declined the interview. It was over a six-week period.

Sampling Technique

Purposive sampling method was used. In purposive sampling, individuals are chosen to participate in the research because they have certain experiences and knowledge of a specific phenomenon, reside in a specific location, or some other reason.[9] This sampling method allows the deliberate selection of individuals and/or research settings that will enable the gathering of information to answer research questions.[9] It is the primary sampling approach used in qualitative research.[10,11]

The Principal Investigator (PI) interviewed two sets of persons. The first set comprised 10 predetermined key informants mainly from the health sector. Key informants are persons with enormous knowledge and/or impact and can shed light on issues of interest. In this study they included the following officials: one person each from MDC, MOH, KBTH and AGD, two each from GHS and the GARH, one private legal practitioner and a patient advocate. These individuals were selected to participate in the research as they were officials of regulatory and other agencies deemed to have knowledge and experience in the administration and practices of the health sector of Ghana. They had also been involved in medical litigation. In particular, the private legal practitioner handles human rights cases including those from the health sector. The other set of interviewees were six persons – two patients and four patient relations. These were chosen because they had experienced a medico-legal issue directly (the patients) or indirectly (patients' relations). The administered questionnaire consisted of four parts. The first part was the demographics which was answered by every interviewee. The second part consisted of questions answered by all victims (patients) and patients' relations. The third part consisted of general questions answered by all officials, while the last part was customised to the specific category of officials interviewed. The questionnaire (interview guide) is attached as appendix.

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Data Source

A primary data source was used to gather the data. Primary data source is the data collected for a specific reason, that is, data collected originally from the source, first-hand (new data would be collected directly). This data type is unpublished, valid, and objective compared to secondary data. A semi-structured interview guide was used.

Research Instrument and Data Collection Procedure

Recorded interviews were conducted. Participants were informed that interviews were going to be audio-recorded and their permission was sought. Consenting participants were told that they were at liberty to stop the recording at any point during the interview. The duration of the interviews was between 20 and 90 minutes, the average duration was about 45 minutes.

Reliability and Validity

Reliability is how consistently a particular research method measures a specific variable. A measurement is considered reliable if the same result can be repeatedly obtained by using the same method under the same conditions.[12] Each category of study participants was administered the same questionnaire. The responses received for the various questions were identical, showing the questionnaire was reliable. Validity refers to the process by which researchers can establish that their findings are authentic to the experiences of the participants. It assesses the quality and rigor of the study[9] which our study showed.

Data Handling and Analysis

The participants interview guides were coded. The audio recordings were transcribed and coded to conform to that used for the guides. A commercial entity was contracted to transcribe the audio recordings. To ensure confidentiality, a confidentiality agreement was signed before the commencement of the work. The transcripts were secured in a passworded file on a computer. The data was analysed using thematic analysis.

Ethical Considerations

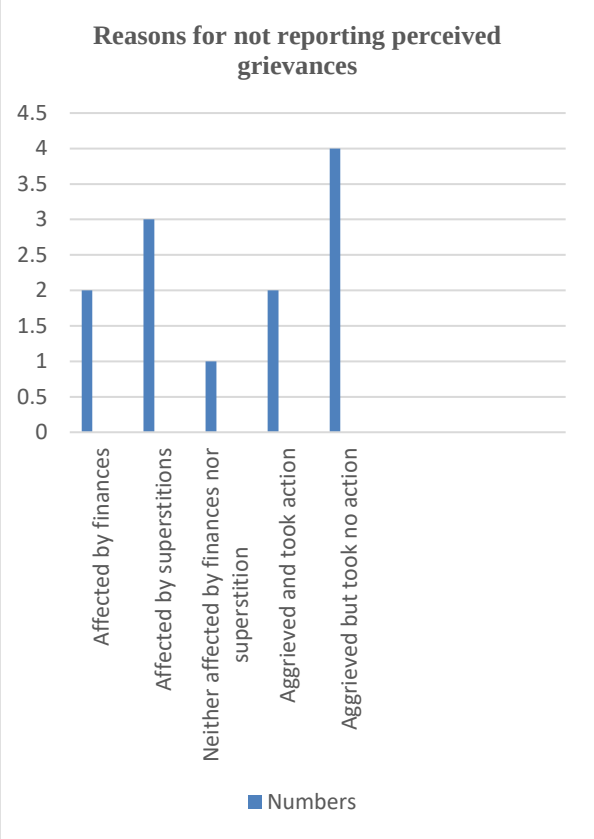
- Ethical approval was obtained from the GIMPA Ethical Review Board, a copy attached.
- A written informed consent was obtained from all the participants.
- Data was in the custody of the PI.
- The transcriber signed a non-disclosure agreement, valid for 3 years.
- All recordings were coded using unique serial numbers to ensure anonymity.

Results

The table below shows a total of six respondents made up of two patients and four patient relations, and their responses in terms of whether they reported their grievances, and which of them did not report based on finances or superstition or otherwise.

One aggrieved respondent who took no action was neither affected by finances nor superstition. He just did not see how he was likely to win a case against a very senior doctor.

		Numbers	%
1.	Affected by finances	2	33.3
2.	Affected by superstitions	3	50.0
3.	Neither affected by finances nor superstition	1	16.7
4.	Aggrieved and took action	2	50.0
5.	Aggrieved but took no action	4	66.7



Bar Graph showing respondents affected by finances or superstition and those who were not so affected.

Interviewees believed in fatalism which is that some happenings in our life are predetermined and will happen as and when they will, and nothing can stop them. One interviewee responded:

"Until recently, the issue of malpractice was left to superstitious beliefs, because a lot of people believe that if it is not your turn to die, you won't die. People think that it is only God who determines who dies and at what point in time. So, for that matter, if you go to

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the facility and something unfortunate happens and you die, then it is your time to die….".

For the reason for not complaining formally following a medical mishap, interviewees' responses included the ignorance of what constitutes a mishap.

A respondent said:
"……..people [the public] *don't even know that there is a remedy or there are rights in law when you* [the patient] *fall victim to medical negligence. For a lot of people, precedence has told them that, 'Look, uh, even if you go to talk about it* [the mishap]*, it won't end anywhere, so why worry yourself" just leave it!'…….*

Also, the long, emotionally exacting, and expensive adjudication process was found to be deterring as some interviewees complained:

'Look, we don't have money because litigation is expensive- you waste money. Also, it can take many years before a verdict is given; so why should we [complainants] *bother ourselves? The person is already dead. Making claims or seeking justice would not bring the person back to life, so, let it be'. I mean let's leave it* [forget about the mishap].

Additionally, it was found that many interviewees were laid back with reporting issues, speaking up against the wrongs of society or even litigating. One respondent said:

"……my in-laws, family and pastor said uh, (hisses) the usual Ghanaian thing, 'gyai ma no ka' [let sleeping dogs lie]. *They said it* [the death] *has already happened, and (hisses) so it was not necessary. So, I shouldn't sue because it would be a waste of time as she had already died and it* [suing] *won't bring her back. I also thought, 'Yeah, you can't fight an institution and win', you'll just be bullied"* (Abdul, patient's relation).

I mean a lot of patients are intimidated by some of these issues [medico-legal issues] *that come up, hence they're unable to speak up when they become victims of malpractice"* (Torgbui, patients advocate).

Finally, the procedures in place at the health facilities to address complaints from service users are considered non transparent and prejudiced against the complainant.

Therefore, the victims would rather go to the court of public opinion to complain where they know they would be heard, sympathised with, and judged most kindly. These points are alluded to by these quotes:

"Mm, they [the complainants] *don't trust in the laid down procedures. `They presume that the facility would shield its own by covering up any untoward findings. However, at the radio stations at least you get the attention and people to sympathize with you. There are instances where people will say that 'I don't like the team that you have put together. I want to bring my own team to come and investigate.'*

Also, perhaps the promptness of response to their issues, is a challenge. So, they want to go out there, and get the public to just bash [castigate] *us and then we'll fall in line* [act professionally] (laughs) ……" (Ama, nurse).

Discussion

The findings are supported by the 2014 Healthwatch report 'Suffering in Silence' which found out that less than 50% of victims of malpractice report the incident. The reasons are either because they are ignorant of the complaint process or because they doubt that anything noteworthy would result from the complaint made.[13] Therefore, even when one is unjustly treated there is the likelihood that no redress would be sought. In fact, even if the victim tries to take the matter up, it is most likely that the family, friends, and society in general may impress upon the one to 'allow sleeping dogs lie'.

The belief of the African that every occurrence in this world is attributable to a higher power and certainly our entry and exit from it, contributes to our non-reporting. This is borne from a respondent's quotation above that, "*People think that it is only God who determines who dies and at what point in time".* This may explain the 'give it to God' attitude that most people are socialised into.

Also, the protracted, emotionally draining and costly nature of the judicial process, is a factor for this non-reporting.

The average Ghanaian has low income and hence any endeavour that is financially exacting is deterring. In 2019, the monthly individual living wage in Ghana was reported to be about GHS 900.00 (about USD 154.78), which was an increase of about GHS 40.00 (about USD 6.87) from the previous year.[14]

The case of *Dr E L A Chinbuah and Captain J K Nyamekye v The Attorney General* wa as determined, after five years.[15] One can imagine how much money was spent. Unfortunately, one of the plaintiffs passed on during this arduous court process.

Furthermore, the Ghanaian is generally laid back with respect to registering their disapproval with issues that boarders on their ill treatment. *There is a certain culture of silence in Ghana.* Unfortunately, when a person tries to defy the status quo, neighbours and relations impress upon him/her to 'move on'. This is reflected in another response that, *"gyai ma no ka"* [let sleeping dogs lie].
The fact that potential complainants consider the complaint procedures at the health facilities non transparent and prejudiced against them is another factor. This is evidenced by the quote, *"Mm, they* **[the complainants]** *don't trust in the laid down procedures. They presume that the facility would shield its own by covering up any untoward findings.* Patients are generally suspicious of the system and any finding that exonerates the system, is judged as confirming their

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perception. They find more solace in the media, especially the electronic and social media which serve as courts of public opinion, and sympathetic to their plight.

Melberg et al found that the populace may just lack information about what constitutes a medico-legal case and how to go about reporting same.[16] This corroborates our finding that the populace is largely ignorant of medico-legal issues. This is supported by the report of the 2014 Healthwatch report 'Suffering in Silence' which found that less than 50% of victims of malpractice reporting the incident. The reasons are either because they are ignorant of the complaint process or because they doubt that anything noteworthy would result from the complaint made.[13] The fatalistic belief of the Ghanaian comes into play. 'Whatever will happen will happen'. Thus, death will occur not so much because of one's negligence but that it is bound to happen. Some supernatural powers are responsible for our entry and exit from the world. No one comes earlier nor leaves later than is predetermined. This responsibility is not bequeathed to any mortal. In effect there is a feeling of learned helplessness where one believes death or malpractice or negligence is outside one's ability to prevent and once it occurs, there is nothing that can be done.

Limitations

The sample size of fifteen sixteen (16) key informants was too small to allow for generalization. A future study will require a larger sample size.

Another limitation was the small number of facilities used for the interviews. That did not allow for a variety of responses. A future study will need to use many more facilities from different parts of the country.

Finally, the profession of the PI (as a medical doctor) may have interfered with the responses received: the complainants may have been apprehensive about speaking frankly to the issues due to the fact that the complaints were about the colleagues of the interviewer.

Conclusion

The dissatisfied client may complain formally through the laid down processes at the health facility or informally in the media, that is electronic or print. Often, the latter is preferred as most of the clients have no confidence in the formal process due to a variety of reasons. These include lack of clarity for the process, and the presumption that the healthcare worker would be shielded. Other reasons are the long and expensive adjudication process, the fatalistic views about life of the Ghanaian, leading to laid back attitudes and general ignorance about what constitutes medico-legal issue. It is recommended that more public awareness is created among clients and the populace to understand their rights and to empower them to be able to stand up for their rights. Medical personnel must also be taken through in-service or continuous professional development to recognise the need to be circumspect with respect to medico-legal issues and to accept and apologise when such negligence occurs to reduce the chances of medico-legal suits.

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